STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM

January 22, 2016

To: Medical Day Care Centers

From: Marc A. Blowe, Chief
Division of Community Long Term Care

Note: Please ensure that appropriate staff members in your organization are informed of the contents of this memorandum.

Re: Medical Day Care Waiver Participants - Interim changes to DHMH 3871B Continue Stay Reviews

---

Per the previous transmittal sent to providers on January 12, 2016, Telligen will be assuming responsibility for performing utilization review services formerly conducted by Delmarva Foundation for Medical Care. The Department is working diligently with both Delmarva and Telligen to implement a smooth transition. To bridge the transition between the two vendors, the Department will take over certain responsibilities.

Delmarva will accept and process all Medical Day Care Waiver DHMH 3871B requests submitted through close of business Friday, January 22, 2016. For the week of January 25, please hold all submissions.

Beginning Monday, February 1, 2016, providers must upload the DHMH 3871B, and any additional documentation necessary, to the LTSSMaryland system. You can do this by logging into https://ltssmaryland.org, searching for your participant, clicking on Case Management, then Client Attachments. From there, you will be able to "Add New Attachment." Please see the updated DHMH 3871B attached.

Once you have completed the uploads, you must send an email to dhmh.MERfax@maryland.gov. The subject line should be "MDC." The body of the email should include each participant's initials and their LTSSMaryland Client ID number. For example, Jane Doe's Client ID will look like "JD123456AB901234". This will help the Department access the information in a secure manner without putting personal health information at risk.

All uploads must be complete and include all necessary attachments. **The Department will return all requests that include old or incomplete forms.**

We appreciate your patience during this transition. Any questions regarding the transition may be directed to evonda.green-bey@maryland.gov or by phone to 410-767-1475.

Maryland Medical Assistance
Medical Eligibility Review Form #3871B

Part A – Service Requested (*indicates required field)

*1. Requested Eligibility Date_____ 2. Admission Date_____

*3. Check Service Type Below:

☐ Nursing Facility-please attach PASRR documentation if necessary (see Part F)

☐ Program of All-Inclusive Care for the Elderly (PACE) ☐ Brain Injury Waiver

☐ Chronic Hospital/Special Hospital vent dependent only (all other CH/SH use 3871) – please attach the Supplemental Ventilator Questionnaire

☐ Model Waiver vent dependent only (all other MW use 3871) – please attach the Supplemental Ventilator Questionnaire

☐ Medical Adult Day Care (new applicants currently placed in a hospital or nursing facility only)

*4. Check Type of Request

☐ Initial ☐ Conversion to MA ☐ Medicare ended ☐ MCO disenrollment

☐ Readmission– bed reservation expired (NF) ☐ Transfer new provider ☐ Update expired LOC ☐ Corrected Da

☐ Significant change from previously denied request ☐ Recertification (MW/PACE only)

☐ Advisory (please include payment)

*5. Contact Name_____ *Phone_____ *Fax_____

*E-Mail_____ *Organization/Facility_____

Part B – Demographics (* indicates required field)

*1. Client Name: Last twhaha h_____First _____ MI ___ Sex: M F (circle)

*SS# _____- ____- _____ * MA # _____ *DOB _____

*2. Current Address (check one) ☐ Facility ☐ Home

*Address _____*City _____*State_____ *ZIP_____ *Phone_____

Nursing Facility name (if applicable) _____Provider #_____

If in acute hospital, name of hospital_____

*3. Next of Kin/ Representative

*Last name _____ *First Name _____ *MI _____

*Address _____ *City_____ *State____ *ZIP_____ *Phone_____

*4. Attending Physician

*Last name _____ *First Name _____ MI _____

Address _____ *City_____ *State_____ *ZIP_____ *Phone_____

Part C – Diagnoses

*Primary diagnosis related to the need for requested level of care	*ICD-10 Code	*Description
Other active diagnoses related to the need for requested level of care	Descriptions	

Applicant Name _____

Part D – Skilled Services:

Requires a physician's order. Requires the skills of technical or professional personnel such as a registered nurse, licensed practical nurse, respiratory therapist, physical therapist, and/or occupational therapist. The service must be inherently complex such that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. Items listed under Rehabilitation and Extensive Services may overlap.

Table I. Extensive Services (serious/unstable medical condition and need for service)

Review Item	# Days Required
1. Tracheotomy Care: All or part of the day	
2. Suctioning: Not including routine oral-pharyngeal suctioning, at least once a day	
3. IV Therapy: Peripheral or central (not including self-administration)	
4. IM/SC Injections: At least once a day (not including self-administration)	
5. Pressure Ulcer Care: Stage 3 or 4 and one or more skin treatments (including pressure-relieving bed, nutrition or hydration intervention, application of dressing and/or medications)	
6. Wound Care: Surgical wounds or open lesions with one or more skin treatments per day (e.g., application of a dressing and/or medications daily)	
7. Tube Feedings: 51% or more of total calories or 500 cc or more per day fluid intake via tube	
8. Ventilator Care: Individual would be on a ventilator all or part of the day	
9. Complex respiratory services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	
10. Parenteral Feeding or TPN: Necessary for providing main source of nutrition.	
11. Catheter Care: Not routine foley	
12. Ostomy Care: New	
13. Monitor Machine: For example, apnea or bradycardia	
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime or perform self care or treatment skills for recently diagnosed conditions (**must be ordered by a physician)**	

Table II. Rehabilitation (PT/OT/Speech Therapy services) Must be current ongoing treatment.

Review Item	# Days Required
15. Extensive Training for ADLs. (restoration, not maintenance), including walking, transferring, swallowing, eating, dressing and grooming.	
16. Amputation/Prosthesis Care Training: For new amputation.	
17. Communication Training: For new diagnosis affecting ability to communicate.	
18. Bowel and/or Bladder Retraining Program: Not including routine toileting schedule.	

Part E – Functional Assessment

Review Item	
FUNCTIONAL STATUS: Score as Follows **0 = Independent:** No assistance or oversight required **1 = Supervision:** Verbal cueing, oversight, encouragement **2 = Limited assistance:** Requires hands on physical assistance **3 = Extensive assistance:** Requires full performance (physical assistance and verbal cueing) by another for more than half of the activity. **4 = Total care:** Full activity done by another	**Score Each Item (0-4)**
1. Mobility: Purposeful mobility with or without assistive devices.	
2. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also, transferring to and from toileting, tub and/or shower.	
3. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair and face.	
4. Dressing: The act of laying out clothes, putting on and removing clothing, fastening of clothing and footwear, includes prostheses, orthotics, belts, pullovers.	

Applicant Name _____

5. Eating: The process of putting foods and fluids into the digestive system (including tube feeding).		
6. Toileting: Ability to care for body functions involving bowel and bladder activity, adjusting clothes, wiping, flushing of waste, use of bedpan or urinal, and management of any special devices (ostomy or catheter). This does not include transferring (See transferring item 16 above).		
CONTINENCE STATUS: Score as Follows **0 = Independent:** Totally continent, can request assistance in advance of need, accidents only once or twice a week or is able to completely care for ostomy. **1 = Dependent:** Totally incontinent, accidents three or more times a week, unable to request assistance in advance of need, continence maintained on toileting schedule, indwelling, suprapubic or Texas catheter in use or unable to care for own ostomy.	**Score Each Item (0-1)**	
7. Bladder Continence: Ability to voluntarily control the release of urine from the bladder	1	
8. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel.	1	
Review Item	**Answer**	
Cognitive Status (Please answer Yes or No for EACH item.)	**Y**	**N**
9. Orientation to Person: Client is able to state his/her name.	☐	☐
10. Medication Management: Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	☐	☐
11. Telephone Utilization: Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
12. Money Management: Can manage banking activity, bill paying, writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	☐	☐
13. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐
14. Brief Interview for Mental Status (BIMS): Was the examiner able to administer the complete interview? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent.)	☐ Yes Score 747 ☐ No Check one of the following: ☐ Hearing Loss ☐ Applicant is rarely/never understood ☐ Language Barrier ☐ Refused ☐ Other (specify)_____	
Behavior (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
15. Wanders (several times a day): Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
16. Hallucinations or Delusions (at least weekly): Seeing or hearing nonexistent objects or people, or a persistent false psychotic belief regarding the self, people, or objects outside of self.	☐	☐
17. Aggressive/abusive behavior (several times a week): Physical and verbal attacks on others including but not limited to threatening others, hitting, shoving , scratching, punching, pushing, biting, pulling hair or destroying property.	☐	☐
18. Disruptive/socially inappropriate behavior (several times a week): Interferes with activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behavior, disrobing in public, smearing/throwing food/feces, hoarding, rummaging through other's belongings, constantly demanding attention, urinating in inappropriate places.	☐	☐
19. Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self, biting, scratching, picking behaviors, putting inappropriate object into any body cavity, (including ear, mouth, or nose), head slapping or banging.	☐	☐
Communication (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
20. Hearing Impaired even with use of hearing aid: Difficulty hearing when not in quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice or totally deaf.	☐	☐
21. Vision Impaired even with correction: Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind.	☐	☐
22. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier).	☐	☐

23. Please provide any additional information that you believe supports that the client's health care needs cannot be safely met outside a nursing facility or in the absence of MADC, PACE, or Waiver services (use an addition sheet if necessary). You are strongly encouraged to use the 3871B Addendum and/or attach medical records for this purpose.

Part F – For Nursing Facility Applicants Only - ID/RC/MI Please Complete the Following

Review Item - If any of the below questions are answered Yes, please complete and attach the full Level I screen (DHMH 4345). If the Level I screen indicates that a Level II evaluation is necessary, please attach either the Categorical Advance Group Determination Form or certification that the person has been approved for admission under PASRR.	**Answer** Y	N
1. Is there a diagnosis or presenting evidence of intellectual disability/related condition (ID/RC), or has the client received services related to intellectual disability/related condition within the past two years?	☐	☐
2. Is there any presenting evidence of mental illness (MI)?	☐	☐
a. If yes, check all that apply. ☐ Schizophrenia ☐ Personality disorder ☐ Somatoform disorder ☐ Panic or severe anxiety disorder ☐ Mood disorder ☐ Paranoia ☐ Other psychotic or mental disorder leading to chronic disability		
3. Has the client received inpatient services for mental illness within the past two years?	☐	☐
4. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis? a. If yes, is the mental illness or psychiatric diagnosis controlled with medication?	☐ ☐	☐ ☐
5. Is the client a danger to self or others?	☐	☐

Part G – Certification

1. Signature of Person Completing Form: _____ Date_____

Printed Name_____ Title_____

I certify to the best of my knowledge the information on the form is correct.

Signature of Health Care Professional: _____Date_____

Printed Name_____ Title_____

UCA/DHMH Use Only ☐ Approved ☐Denied Date of Decision_____

Certification Period _____

Signature_____ Date Signed_____

Print Name Title